MEDICAL DAY TREATMENT PROVIDER HANDBOOK
APPENDICES

APPENDIX 1a
MEDICAL DAY TREATMENT SERVICES

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
(Medicare #) [P] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)						1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Recipient, Im A.			MM DD YY				
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)	
609 Willow St.			Self [ ] Spouse [ ] Child [ ] Other [ ]				
CITY		STATE	8. PATIENT STATUS			CITY	STATE
Anytown, [illegible]		WI	Single [ ] Married [ ] Other [ ]				
ZIP CODE	TELEPHONE (Include Area Code)		Employed [ ] Full-Time Student [ ] Part-Time Student [ ]			ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
55555	(XXX)XXX-XXXX						( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER	
OI-P							
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]			b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? [ ] YES [ ] NO			c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
I. M. Referring MD			12345678				
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 296.5 2. ____ 3. ____ 4. ____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 03 92		2	1	W8913		1	XX XX	1.0				
2 01 10 92	14 16	2	1	W8911		1	XX XX	3.0				
3 01 21 92		2	1	W8911		1	XX XX	1.5				
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[ ] [ ]	1234JED	[ ] YES [ ] NO	$ XXX XX	$ XX XX	$ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M.Authorized MM/DD/YY		I. M. Billing 1 W. Williams Anytown, WI 55555
SIGNED DATE		PIN# 76543210 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 1b
ELECTRONIC MEDIA CLAIMS MEDICAL SCREEN

MEDICAL ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form.

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010493
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23 LAB 20
RP NBR 17 FP NBR 32 OP NBR
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
0													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #5 Form: MEDICAL/MEDVENDR 01-04-1993 14:59:02

BENEFITS OF ELECTRONIC BILLING
One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data element that are not required on electronic claims include:

- claim sort indicator
- patient's date of birth
- patient's address
- patient's sex
- signature of provider
- provider's name and address

Other benefits of billing electronically include:

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

APPENDIX 2
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter the appropriate claim sort indicator "P" in the Medicaid check box. Claims submitted without the appropriate indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Health insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c and 9d are not required.)

Code	Description
OI-P	PAID in part by health insurance. The amount paid by health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, the card indicated other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services provided by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed for covered services prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amount on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed have the same procedure code.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for each procedure is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service.

Numeric	Description
2	Outpatient Hospital
3	Office

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code.

Code	Description
1	Medical Services (Medical Day Treatment)

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Indicate the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. Use a decimal when a fraction of a whole unit is billed.

Minutes Billed	Quantity	Minutes Billed	Quantity
1-6	.1	31-36	.6
7-12	.2	37-42	.7
13-18	.3	43-48	.8
19-24	.4	49-54	.9
25-30	.5	55-60	1.0

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of to a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, indicate "OI-P" in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 3
PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: ______________________________
Address: ______________________________
____
____

Medicaid Number: ______________ **Phone #:** ______________________
Contact Person: ______________________________
Type of Service(s) Provided: ______________________________
Estimated Monthly Medicaid Claims Filed: ______________________________

• •

1. Do you currently submit your Medicaid claims on paper? __YES __NO

2. Are your Medicaid claims computer generated on paper? __YES __NO

3. Do you use a billing service? __YES __NO
   If the answer is YES to #2 or #3, please complete the following:
   Name: ______________________ Contact: ______________
   Address: ______________________ Phone #: ______________
   ____

4. Do you have an in-house computer system? __YES __NO
   If YES, type of computer system:
   a. Large main frame — Manufacturer: ______________
      (e.g., IBM 360, Burroughs 3800) — Model #: ______________
   b. Mini-Computer — Manufacturer: ______________
      (e.g., IBM System 34, or 36 TI 990) — Model #: ______________
   c. Micro-Computer — Manufacturer: ______________
      (e.g., IBM PC, COMPAQ, TRS 1000) — Model #: ______________

5. Please send the paperless claims manual for:

   __ magnetic tape submission

   __ telephone transmission (EDS free software) ___ 3-1/2" ___ 5-1/4"

   __ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009

APPENDIX 4
HCPCS PROCEDURE CODE AND COPAYMENT TABLE FOR MEDICAL DAY TREATMENT SERVICES

Procedure Code	Description	Copayment
W8910	Day Treatment Inpatient Recipient (1 hour)	$ .50/day
W8911	Day Treatment Outpatient Recipient (1 hour)	$ .50/day
W8912	Day Treatment Nursing Home Recipient (1 hour)	$ .50/day
W8913	Functional Assessment Positive Dx (1 hour)	$ .50/day
W8914	Functional Assessment Negative Dx (1 hour)	$ .50/day
W8988	Limitation-Exceeded Functional Assessment (POS)/1 hour	$2.00/hour
W8989	Limitation-Exceeded Functional Assessment (NEG)/1 hour	$2.00/hour

APPENDIX 5
WMAP ALLOWABLE PLACE OF SERVICE (POS) AND TYPE OF SERVICE (TOS) CODES FOR MEDICAL DAY TREATMENT SERVICES

PLACE OF SERVICE CODES

Code	Description
2	Outpatient Hospital
3	Office

TYPE OF SERVICE CODE

Code	Description
1	Medical Services (medical day treatment)

APPENDIX 6
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 129

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX - XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 76543210

10 DX: PRIMARY: 295.3 - schizophrenia

11 DX: SECONDARY: 301.8 - passive aggr. person

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8911		3	1	Day Treatment	10	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 7
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) COMPLETION INSTRUCTIONS

ELEMENT 1 - PROCESSING TYPE
Enter "129".

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Indicate the recipient's 10-digit Medical Assistance identification number from the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Indicate the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Indicate the address of the recipient's place of residence; the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Indicate the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Indicate an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Indicate the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be indicated in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Indicate the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Indicate the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service requested.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Indicate the appropriate procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Indicate the appropriate place of service code designating where the requested service would be provided.

Code	Description
2	Outpatient Hospital
3	Office

ELEMENT 17 - TYPE OF SERVICE
Indicate type of service code "1" to signify medical day treatment services.

ELEMENT 18 - DESCRIPTION OF SERVICE
Indicate a written description corresponding to the appropriate procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Indicate the number of hours for each service requested.

ELEMENT 20 - CHARGES
Indicate your usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Indicate this total in element 20.

> *NOTE:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance managed care program at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the managed care program."

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting the service must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 8
PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DTA

PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	29

PROVIDER INFORMATION

(6) REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS	(7) REQUESTING/PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) REQUESTING/PERFORMING PROVIDER'S PROVIDER TELEPHONE NUMBER
I. M. Requesting	76543210	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PROVIDER'S NAME	(10) REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
I. M. Referring	12345678

A. Number of hours per week requested 10 hrs/wk

B. Estimated final treatment date 12/92 and after

C. Has the recipient had previous Day Treatment at your facility or elsewhere?
☒ Yes ☐ No ☐ Unknown
If "Yes", list dates and locations:

Client began Day Treatment on DD/MM/YY and has had 6 months of intensive treatment.

D. Evaluation(s): (Dates, Tests Used and Results)

MM/DD/YY functional assessment
MM/DD/YY psychiatric interview
MM/DD/YY clinical interview

E. Attach page one (1) of the recipient's most recent Function Assessment Scales.
(Functional Assessment must be signed and dated within 3 months of receipt by EDS)

F. Is the recipient's intellectual functioning below average?
☐ Yes ☒ No
If "yes", what is the recipient's IQ score or intellectual functioning level, and how was this measured?

G. **Provide a brief history, pertinent to requested services (include psycho-social history, hospitalization history, family history, living situation history, etc.).**

According to available records this client has been in and out of institutions for 10 years. The active phase of her illness occurred 10 years ago. Client throughout her history has shown bizarre decisions, auditory hallucinations, loosening of associations, and inappropriate affect. This client while in the active phase, has pulled a knife on her family which warranted an emergency detention. This occurred 1 year ago. As a result, client was placed in a group home after being stabilized in the hospital. Her family currently has decided not to be involved with her.

H. Progress/status since treatment began or was last authorized:

Client is currently stabilized with medication. However periodic auditory hallucinations appear to be occurring. Client has been able to perform vocational tasks through our workshop and participates in this 2 days/wk. under stress client has a high potential of having an exacerbation of psychotic symptoms. With continued support she has been able to remain in the community.

I. Specify overall character of service to be provided:

☐ Rehabilitation ☒ Maintenance ☐ Stabilization

J. Identify measurable treatment goals:

1) The major goal of Day Treatment is to help maintain this client in the community. This will be measured by a decrease in hospitalizations.

2) Client will be supported for acceptance of her disease by continued willingness to take medications, and continued verbalizations of this in a group. This will also be measured by regular attendance in all groups..

3) Client will continue to learn ADL skills and problem solving skills. This will be demonstrated by increased independence in her group home and at her vocational placement.

4) Client will be monitored for changes in emotional, social, and task skills as measured by functional assessment.

K. Attach a specific schedule of activities, to include day, time of day, length of session and service to be provided:

See Attachment

L. Rehabilitation Potential: estimate the recipient's potential for Employment (competative, supported, sheltered, etc.) Social Interaction, Independent Living

It appears that client has reached maximum potential at this time. Because of the chronic nature of her illness, client's potential for employment is poor. However, with consistent structure, her potential placement in a sheltered workshop and independant living situation is good.

M. **Recipient Authorization**

I have read the attached request for prior authorization of Day Treatment services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative (If representative, state relationship to recipient) _____ Relationship _____

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

N. D. M. Prescribing — Signature of Prescribing Physician — MM/DD/YY — Date

I. M. Performing — Signature of Therapist Providing Treatment — MM/DD/YY — Date

Signature of 51.42 Board Director/Designee — Date

APPENDIX 9
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) or the Prior Authorization Day Treatment Attachment (PA/DTA) may be addressed to EDS' Correspondence Unit for Policy/Billing Information. Refer to Appendix 2 of Part A of the Wisconsin Medical Assistance Program (WMAP) provider handbook for the telephone numbers.

RECIPIENT INFORMATION

ELEMENT 1 - RECIPIENT'S LAST NAME
Indicate the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Indicate the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Indicate the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Indicate the recipient's ten-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Indicate the age of the recipient in numerical form.

PROVIDER INFORMATION

ELEMENT 6 - REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS
Indicate the name and the credentials of the provider requesting prior authorization.

ELEMENT 7 - REQUESTING/PERFORMING PROVIDER NUMBER
Indicate the eight-digit Medical Assistance provider number of the provider requesting prior authorization.

ELEMENT 8 - REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER
Indicate the telephone number, including area code, of the requesting provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Indicate the name of the referring/prescribing provider.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Indicate the eight-digit Medical Assistance provider number of the referring/prescribing provider.

* *

"Day Treatment" or "Day Hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies and follow-up services, to alleviate problems related to mental illness or emotional disturbances. Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills." HSS 101.03(37).

The target population for extended day treatment services are the chronically mentally ill (CMI) or those that have an acute exacerbation of a chronic mental disorder (supported by diagnosis and narrative summary).

Rehabilitation
This category is used for all of the target day treatment population who may benefit by intensive day treatment.

Maintenance
This category is for those recipients, who by diagnosis and history, are suffering from a chronic mental disorder as indicated by diagnosis, signs of illness for two or more years, and past intensive day treatment has already been tried for six months, or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to maintain the individual in the community and prevent hospitalization.

Stabilization
This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure to stabilize the recipient, to prevent harm to self and/or others, and/or to prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) and/or other acceptable signs of clear deterioration (in level and course of functioning).

* *

The remaining portions of this attachment are to be used to document the justification for the service requested.

1. Complete elements A-N. The recipient's signature in element M is optional. The signature of the 51.42 Board Director, in element N, is not required.

2. Attach a photocopy of the demographic sheet of the functional assessment form to this attachment.

3. Attach a photocopy of the physician's current prescription for medical day treatment to the attachment form. The prescription must be dated within one month of receipt by EDS.

4. Read the Prior Authorization Statement before dating and signing the attachment.

5. The attachment must be dated and signed by the provider requesting or providing the service.

APPENDIX 10
GENERAL CONSULTANT GUIDELINES FOR PRIOR AUTHORIZATION OF MEDICAL DAY TREATMENT SERVICES

1. The target population for extended day treatment services are the chronically mentally ill (CMI) or those that have an acute exacerbation of a chronic mental disorder (supported by diagnosis and narrative summary).

2. Diagnostic limitations (DSM-III-R) for medical day treatment services are:

   a. Acceptable diagnoses

      - Certain Psychoses - 295 (Schizophrenic Disorders), 296 (Affective Psychoses), and 298 (Other Nonorganic Psychoses).

      - Other Disorders - 301 (Personality Disorders) and 311 (Depressive Disorder, not elsewhere classified).

   b. Possible diagnoses (with careful scrutiny) - 300 (Neurotic Disorders), usually limited to 300.11, 300.3, 300.4, 300.81, and 300.9 (the narrative must document interference in life functioning).

   c. All other diagnoses are deemed inappropriate for medical (generic) day treatment (i.e., 290-294, 297, 299, 302-310, 312-316). An explanation must be documented and may be approved at the consultant's discretion.

3. The request must include a Functional Assessment, completed within three months of the request's internal control number (ICN) date. Requests not meeting this criteria should be returned to the provider. (Refer to HSS 107.13(4)(b)f, Wis. Admin. Code, for more information.)

4. A recipient must have at least a 50 percent likelihood to benefit from day treatment in order to qualify for Medical Assistance reimbursement, as indicated in the Functional Assessment.

5. The recipient must be 18 years of age or older to qualify for day treatment services covered by these guidelines.

6. Those recipients suffering from acute mental illness (AMI) or a mild mental disorder (i.e., by diagnosis and history are not suffering from a chronic malady) are generally eligible for hours of treatment preceding the prior authorization threshold. Additional hours may be approved at the consultant's discretion.

7. A recipient with 317 (Mental Retardation) as the only or as the primary diagnosis is not eligible for day treatment services.

8. A recipient whose I.Q. is 65 or less is not ordinarily eligible for day treatment services. The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.

9. A recipient who, according to the documentation submitted, is currently abusing alcohol or other drugs is generally not eligible for medical day treatment services. Day treatment may be approved at the consultant's discretion if evidence of concurrent AODA treatment is presented. However, no intensive outpatient AODA and day treatment may be approved concurrently.

10. A recipient who, by narrative description, is primarily a victim of parental/relationship alcoholism, drug abuse, physical abuse, sexual abuse, or incest, is not generally eligible for generic day treatment services.

    The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.

11. A recipient who, by narrative description, has an identified eating disorder, sexual addiction, or other compulsive/addictive malady, is not generally eligible for generic day treatment services.

    The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.

12. The following categories with hour and time limitations, along with consultant knowledge of the recipient's needs, provider and program offered, are to be used in deciding authorization for the target populations. (Refer to numbers 1 and 2 above.)

    a. Rehabilitation: This category is used for all of the target day treatment population who may benefit by intensive day treatment. Recipients believed to be in this category would receive, at the consultant's discretion, the following:

        - Threshold hours;
        - One authorization extension for six months (if requested) of up to 25 hours per week; and
        - Two additional authorization extensions of 10 to 25 hours per week for three months, IF and only IF:

            1) Improvement is shown in the Functional Assessment scores (i.e., LOF and COF);

            2) A plan is developed to transfer the recipient to ongoing community support, vocational rehabilitation, therapeutic living arrangement, etc.;

            3) There is evidence this process will be completed within one year (e.g., indicated by termination date, previous performance, rehabilitation potential, and narrative history); and

            4) The narrative indicates that, in the judgement of the provider, rehabilitation potential is "good," or better.

    b. Maintenance: This category is for those recipients who, by diagnosis and history, are suffering from a chronic mental disorder as indicated by diagnosis, signs of illness for two or more years, and past intensive day treatment has already been tried for six months, or more with no apparent change in Functional Assessment, or narrative history. The major goal of treatment here is to maintain the individual in the community, and prevent hospitalization. Recipients in this category would receive, at the consultant's discretion, the following:

        - Authorization extension for 1 to 6 hours per week, for as long as needed (extension length up to 12 months, or the remainder of the calendar year, if requested).

        - Authorization extension may also be granted for 6 to 10 hours per week, for 3 to 12 months (or the balance of the calendar year), depending on the recipient's needs, consultant knowledge of the provider, and the provider's day treatment program.

    c. Stabilization: This category is for those recipients in the target population who decompensate or have an acute exacerbation of a chronic condition. The goal in this category is to "increase structure," stabilize the recipient, and prevent harm to self or others, and prevent hospitalization.

Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) or other acceptable signs of clear deterioration in level and course of functioning. The recipient in this category would receive, at the consultant's discretion, the following:

- Initially an extension of up to 25 hours per week, for a single three-month period.
- Following this, one extension returning to maintenance level (1-10 hours per week), unless rehabilitation potential is clearly demonstrated.

13. Other general considerations for determining medical day treatment hours and eligibility are, at the consultant's discretion, as follows:

    a. The Level of Functioning score (LOF) must be between 3 and 12 to be eligible for day treatment.

    b. The Course of Functioning score (COF) must be between 5 and 12 to be eligible for day treatment.

    c. If the COF is greater than 12, then the risk of hospitalization needs to be at least 75 per cent to be eligible.

    d. If the recipient is in a therapeutic or supportive working and living arrangement (i.e., CBRF, sheltered workshop, group home, foster home, or intact family), then fewer hours are indicated for day treatment.

    e. Discharge from one day treatment program to a vocational rehabilitation (sheltered workshop) setting prohibits another intensive day treatment series, unless other criteria are met.

    f. A recipient who is involved in primary Alcohol and Other Drug Abuse Treatment (AODA) is not generally eligible for medical day treatment services. However, if the recipient has completed primary AODA treatment and is in an after-care service, he or she is eligible for concurrent medical day treatment, at the consultant's discretion. The hours granted would generally fall into the Maintenance category.

    g. The following activities are <u>not covered</u> as medical day treatment hours: meal times, rest periods, transportation, recreation, entertainment, and off-site visits and activities.

APPENDIX 11
SAMPLE MEDICAL DAY TREATMENT FUNCTIONAL ASSESSMENT

WD	F	2	Page
AT	A	30	1
P			

MEDICAL DAY TREATMENT
DEMOGRAPHIC AND CLIENT INFORMATION

(1) ( ) Initial Assessment - (Date) 10/1/91
( ) Reassessment - (Date) 4/1/92
Recipient's Name Im. A. Recipient

(2) Client has received 380 hours of day treatment since initial assessment.

(3) NAME: Last, First, Initial	SEX	BIRTHDATE: Month, Date, Year
Recipient, Im A.	(4) M ( ) F (X)	(5) MM/DD/YY

(6) ADDRESS: Street, City/Village/Town, County, State, Zip	Telephone (7)
609 Willow Anytown, WI 55555	

(8) REFERRAL SOURCE: 1 2 3 4 5 6 7 8* Name/Agency Address	Telephone (9)

(10) PRESCRIBING PHYSICIAN: Name	Address	Telephone (11)
I. M. Physician		

(12)	NAME OF FACILITY/ADDRESS (13)	(14)
Client Presently Hospitalized? Yes ( ) No (X) Client Presently Living in Nursing Home? Yes ( ) No (X)		Since _____ Discharge Date _____

USUAL LIVING ARRANGEMENT

(15)
( ) Alone
( ) Household with spouse and other relatives or with other relatives only
(X) Group quarters, other than a health-related facility
( ) Household with spouse only
( ) Household with non-relatives
( ) CBRF
( ) Other/specify _____

(16) MEDICAID # 1234567890
SSIS # _____
TIS # _____

REASON FOR REFERRAL

(17) To stabilize acting out behavior and monitor SI. Also to increase coping skills.

ELIGIBILITY DECISION CRITERIA

(18) 1. AODA currently Yes ( ) No (X)
(19) 2. MR Primary Diagnosis Yes ( ) No (X)
(20) 3. ICD-9: Primary Diagnosis # 295.3
Secondary & Other # 301.8
(21) 4. Total Score LOF (pages 2-4). 303530 9.5
(22) 5. Likelihood of Benefit (page 5): 90%
(23) 6. Course of Functioning Score (page 5): 8
(24) 7. Risk of Hospitalization (page 5): 85%

CURRENT SERVICES BEING RECEIVED

(25) (Medical and Non-medical):
Psycho Therapeutic Groups, skills group(coping), psychiatric medication evaluations, etc.

(26) NAME OF DAY TREATMENT PROGRAM
I.M. Nurse RN
Signature of Assessor Discipline

I.M. Director
Review of Functional Assessment by Day Treatment Program Director

Signature

AUTHORIZATION

Pursuant to the provisions of HSS 105.245(3)(b), Wis. Adm. Code, I have reviewed this functional assessment and I verify that the service is approved by the board.

(27) BY: _____ N/A
SIGNATURE TITLE DATE

(28) APPROVAL GIVEN FOR: / / Functional Assessment / / Provision of Day Treatment / / Submission of Prior Authorization Request

(29) *REFERRAL SOURCE CODE:
(1) Hospital (3) Friend (5) Self (7) Physician
(2) Family (4) Agency (6) Nursing Home (8) Other

W	D	F	2	Page
M	T	A	80	2
A				
P				

( ) Initial Assessment - (Date) 10/1/91
( ) Reassessment - (Date) 4/1/92
Recipient's Name _____

LEVEL OF FUNCTIONING
TASK ORIENTATION SCALE

Note: You must know first hand or have it reliably documented that the client has actually done the tasks.

Indicators:
a. Degree of self-application (concentration, follow through, assuming responsibility) and if necessary, the amount of guidance (instruction in performance) and support (reinforcement, reassurance) needed to maintain functioning.

b. Relationship of level of stress to task functioning and the amount of support needed to engage or re-engage in tasks.

COMMENTS

1. a. Cannot apply self to any task for any period of time. Demonstrates no goal directed behavior. May wonder aimlessly. Guidance and support have no effect on task functioning.

   b. Cannot cope with any stress.

2. a. Rarely concentrates. When alone, rarely follows through with tasks. In a highly structured situation with others very limited task follow through even with constant guidance and support.

   b. Functioning breaks down with slightest stress. Needs much support to re-engage.

3. (a.) Concentrates intermittently. When alone, limited follow through. Some follow through with continuous support; no guidance necessary.

   (b.) With low stress task functioning breaks down. Support needed to re-engage.

3

4. a. Concentrates fairly consistently. At times able to follow through. Occasionally assumes responsibility for tasks, when requested to do so, if support is provided.

   b. With low stress, task functioning is usually diminished. Support needed to re-engage.

5. a. Follows through frequently and voluntarily assumes responsibility for tasks. Occasionally needs support.

   b. With low stress, functioning will occasionally be impaired. With moderate stress, functioning will almost always be impaired. Usually needs support to re-engage.

6. a. Concentration is consistent and purposeful. Follows through well and often assumes responsibility for tasks, only requiring support when under stress.

   b. With moderate stress, functioning is usually impaired. Can re-engage by self.

7. a. Concentration is almost always consistent and purposeful. Follows through very well and is actively responsible in relation to tasks. Usually follows through even with frustrating tasks. Task mastery is experienced as valuable and satisfying. Very seldom needs support.

   b. With moderate stress can maintain functioning. With high stress functioning is impaired, but can re-engage by self.

8. a. Excellent concentration and achievement orientation. Very seldom subject to distraction. Follows through even with the most frustrating tasks. Almost never needs support.

   b. With high stress, functioning only slightly impaired. Can re-engage by self.

SCORE THIS PAGE
3

W	D	F	2	Page
M	T	A	80	3
A				
P				

( ) Initial Assessment - (Date) 10/1/91
( ) Reassessment - (Date) 4/1/92
Recipient's Name _____

LEVEL OF FUNCTIONING
SOCIAL FUNCTIONING SCALE

NOTE: Social interaction can be in or out of the program. You must know of its occurrence first hand or it must be reliably documented. Social interaction with staff is not to be taken into consideration when rating.

Indicators:
a. Ability to initiate interpersonal contact.
b. Degree of conversational interaction.
c. Degree of comfort in interpersonal situations.
d. Relationship between level of stress and social functioning. Amount of support needed to engage or re-engage.

COMMENT

1. a. Does not initiate contact. When approached, no response.
   b. Shows no ability to listen or respond in conversation.
   c. Extreme discomfort being with others.
   d. Unable to cope with any stress.

2. a. Very rarely initiates contact. When approached, sometimes responds.
   b. Rarely listens. Responses not appropriate to conversation flow (lack of continuity, coherence).
   c. General discomfort with others most of the time.
   d. With the slightest stress functioning breaks down. Needs support to re-engage.

3. a. Rarely initiates contact. If approached, almost always responds.
   b. Sometimes listens Responses occasionally appropriate to conversation flow.
   (c.) Discomfort with others but can tolerate limited supported interaction.
   (d.) With low stress, functioning almost always breaks down. Needs support to re-engage.

3.5

4. (a.) Sometimes initiates contact. Always responds.
   (b.) Usually listens. Responses often appropriate with some sharing in the conversation flow.
   c. Some discomfort but with support can tolerate most interactions.
   d. With low stress, functioning at this level usually diminishes. Needs support to re-engage.

5. a. Often initiates contact.
   b. Can listen well. Usually responds in shared way to the conversation flow.
   c. Usually comfortable with others in interactions that are not stressful.
   d. Under low stress, functioning occasionally breaks down. With moderate stress functioning will almost always be impaired. Usually needs support to re-engage.

6. a. In most cases can initiate contact.
   b. Listens very well. Responds in shared way to conversation flow. At times actively shapes conversation.
   c. Usually comfortable in most interactions.
   d. With moderate stress, functioning is occasionally impaired. Can re-engage by self.

7. a. Almost always able to initiate contact as desired.
   b. Listens with empathy. Not only responds but actively shapes conversation appropriately.
   c. Not only feels comfortable, but experiences interactions as satisfying.
   d. With moderate stress, can maintain functioning. With high stress, functioning diminishes. Can re-engage by self.

8. a. Initiates contacts as desired.
   b. Listens intuitively. Responds and shapes conversation appropriately, as desired.
   c. Not only feels comfortable, but experiences being with others as self-enhancing.
   d. With high stress, involvement may be diminished, but client is not immobilized.

SCORE THIS PAGE
3.5

W	D	F	2	Page
M	T	A	80	4
A				
P				

( ) Initial Assessment - (Date) 12/23/93
( ) Reassessment - (Date) _____
Recipient's Name _____

LEVEL OF FUNCTIONING
EMOTIONAL SCALE

Indicators:
a. Client's ability to be aware of and understand his emotional states.

b. Client's relationship to his emotional states (overwhelmed? sufficiently controlled? a sense of objectivity?).

c. Amount of support needed to function emotionally, with varying levels of stress.

COMMENT

1. a. Emotional states appear to be either extremely controlled and rigid (flat) or extremely uncontrolled (labile). Cannot objectively acknowledge his emotions.
   b. Appears severely overwhelmed by emotional experience.
   c. Intervention or support has no effect. Emotional states prevent almost all everyday functioning.

2. a. Although may refer to emotional states, reveals no experienced awareness or objective understanding of emotions at the time they occur.
   b. Excessively overwhelmed by emotions.
   c. Even with constant support, becomes overwhelmed with slightest stress. Needs support to regain functioning.

3. (a.) Indicates beginning awareness of emotional states, but anxious about this awareness.
   (b.) Emerging objectivity in relation to emotions, though frequently overwhelmed by his emotions. 3
   (c.) Even with constant support, in low stress situations, functioning breaks down.

4. a. Usually aware of emotional states. Indicates an acceptance of emotions as a necessary part of life. May begin to take new actions based on awareness of his emotions.
   b. Some objectivity in relation to his emotions but often feels overwhelmed by them.
   c. Even with frequent support, in low stress situation, functioning is diminished. Needs support to regain functioning.

5. a. Indicates that he is almost always aware of his emotions and is developing an understanding of them.
   b. Somewhat uncomfortable and overwhelmed by his emotions, but still objective enough to begin to understand them.
   c. Even with support, emotional functioning is impaired with moderate stress. Needs support to regain functioning.

6. a. Understands his emotions and how they relate to everyday functioning. Begins to feel comfortable with various emotional states.
   b. Behavior indicates sufficient emotional objectivity to function with flexibility.
   c. Emotional functioning somewhat impaired with moderate stress. At times needs some support to regain functioning.

7. a. Not only understands emotions and how they relate to everyday functioning but experiences this as satisfying, and a part of emotional growth.
   b. In experiencing diverse emotional states, even extremes, person usually maintains a tempering objectivity.
   c. With high stress, functioning will diminish. Occasionally needs support to regain functioning.

8. a. Indicates thorough understanding of his emotional life and experiences emotional growth as part of a lifelong process.
   b. Wide variety of emotions are experienced in a larger context of emotional growth.
   c. With high stress, functioning slightly impaired. No need for support to regain functioning. 3

SCORE THIS PAGE _
TOTAL LOF SCORE _

W	D	F	2	Page
M	T	A	80	5
A				
P				

(X) Initial Assessment - (Date) 12/23/93
( ) Reassessment - (Date) _____

Recipient's Name _____

5. Likelihood of benefit from medical day treatment. In comparison with other individuals' day treatment pre-admission functioning and subsequent benefit from day treatment in achieving treatment goals, what is the probable benefit of medical day treatment to this individual? (check level) SCORE

0% 10 20 25 30 40 50 60 70 75 80 **90** 100%

(No likelihood of achieving treatment goals) (Moderate likelihood in achieving treatment goals) (Complete likelihood in achieving treatment goals) 90%

PREVIOUS COURSE OF FUNCTIONING DURING THE PAST YEAR

6. a. High vulnerability to stress. What is the likelihood that the individual exhibited severe psychopathological symptoms in response to mild to moderate levels of stress?

1 (100%) 2 (75%) 3 (50%) 4 (25%) 5 (0%)

(Complete likelihood of severe psychopathological symptoms) (Moderate likelihood of severe psychopathological symptoms) (No likelihood of severe psychopathological symptoms) 1

b. Deficiencies in activities of daily living skills. What has been the individual's level of functioning with regard to activities of daily living (i.e., bathing, grooming and dressing; basic housekeeping and shopping; use of public transportation; preparing or obtaining meals; maintaining prescribed program of medication; taking initiative to seek assistance with problems; etc.)?

1 2 3 **4** 5

Unable to perform without assistance three or more essential activities of daily living | Unable to perform without assistance two essential activities of daily living | Unable to perform without assistance one essential activity of daily living | Marginal performance of activities of daily living | Adequate performance of activities of daily living

Specify Recipient able to perform lower level skills (ie. bathe, feed self, use toilet, etc.) When stressed has much difficulty with higher level skills of preparing meals, shopping, working, socializing. 4

c. Dependence on institutional and other support systems. To what extent has the individual required mental hospitalizations or other institutional support, or been unable to achieve self sufficient living?

1 2 3 4 5

Has had mental hospital admission | Has been involved in medical day treatment | Has not required medical day treatment or more restrictive care 1

d. Difficulty with working in the competitive job market. To what extent has the individual been unemployed, sporadically employed, or experienced emotionally-related job difficulties?

1 2 3 4 5

Extensive periods of unemployment or serious emotionally-related job difficulties | Moderate difficulty in obtaining or maintaining employment or moderate emotionally-related job difficulty | No significant difficulty with regard to competitive employment 1

e. Difficulty with interpersonal relations. To what extent has the individual exhibited social withdrawal and/or inappropriate behavior that interfered with interpersonal relationships necessary for community living?

1 2 3 4 5

Serious degree of withdrawal and/or inappropriate behavior | Moderate degree of withdrawal and/or inappropriate behavior | No evidence of social withdrawal or inappropriate behavior 1

7. Risk of hospitalization. If the individual does not receive medical day treatment at this time, what is the likelihood of the person requiring inpatient care within the next three months? NOTE: If feasible, this estimate should be made in comparison with other clients with similar diagnoses, levels of functioning, and course of functioning. Also, averaging more than one clinical judgment tends to increase the accuracy of this estimate. (check level)

0% 10 20 25 30 40 50 60 70 75 80 **90** 100%

No likelihood of inpatient care | Complete likelihood of requiring inpatient care 85%

TOTAL 8

APPENDIX 12
MEDICAL DAY TREATMENT DEMOGRAPHIC AND CLIENT INFORMATION COMPLETION INSTRUCTIONS

This form is the face sheet of the functional assessment scales which are required for clients in day treatment who are Wisconsin Medical Assistance recipients. This form must be completed by the day treatment staff before treatment begins, preferably by the client's case manager or by the primary staff person responsible for the person's treatment.

The form must be completed each time a functional assessment is performed. It should be kept in the client's case records. Also, a copy must be sent to the Wisconsin Medical Assistance Program (WMAP) at time of prior authorization request. Do not submit the form with claims for payment.

Print or type the information on the form, so that it is legible.

The numbers of the following items correspond to the numbers appearing on the sample form in Appendix 11 of this handbook.

1. Initial assessment/Reassessment: Check the appropriate space and indicate the date the functional assessment was performed.

2. Client has received...: Complete the statement by indicating the total number of hours of day treatment the recipient has received since the initial assessment.

3. Name: Print the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

4. Sex: Check the appropriate space.

5. Birthdate: Indicate the recipient's birthdate in MM/DD/YY format. For example, March 21, 1959, would be written as 03/21/59.

6. Address: Indicate the recipient's address. If the recipient resides in a nursing home or community based residential facility, indicate the name of the facility in addition to the address.

7. Telephone: Indicate the recipient's home telephone number.

8. Referral Source: Circle the appropriate number corresponding to the type of referral. Refer to the referral codes in item 29 of this form for descriptions of the referral codes. Indicate the name and address of the person or agency making the referral.

9. Telephone: Indicate the referral source's telephone number.

10. Prescribing Physician: Indicate the name and address of the prescribing or referring physician.

11. Telephone: Indicate the prescribing physician's telephone number.

12. Client Presently Hospitalized?/Living in a Nursing Home? Indicate whether the client presently is an inpatient in an acute care general hospital or in a psychiatric hospital, is a resident in a nursing home.

13. Name of Facility/Address: If you checked "yes" to either question in item 12 of this form, indicate the name and address of the facility.

14. Since.../Discharge Date: If you checked "yes" to either question in item 12 of this form, then indicate the date the recipient became an inpatient or resident of the facility. Also indicate the anticipated discharge date (obtained from the facility).

15. Usual Living Arrangement: Check the appropriate space corresponding to the recipient's usual living arrangement.

16. Medicaid #/SSIS #/TIS #: Indicate the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

    If the recipient is receiving Title XX social services through the county social services department, the recipient will have an Social Services Information System (SSIS) number. If you don't know the number, but you know the person is receiving social services (e.g., day care, supportive home care, foster care, etc.) through the county, contact the county social service office to find out the number.

    All recipients will have Transitional Information System (TIS) numbers. TIS numbers are the client identification numbers used by 51.42 boards in reporting to the Department of Health and Social Services on units of services provided in a quarterly reporting period. Each recipient in your program will have a TIS number.

17. Reason for Referral: State briefly the major reason(s) the person was referred to day treatment.

Items 18 through 24 Eligibility Decision Criteria: The information requested in items 18 though 24 of this form makes up the summary of data obtained through performing the complete functional assessment (pages 2-5). Based on the information contained in this section, the recipient may or may not be eligible for Medical Assistance reimbursement of the day treatment services. See the "Decision Rules for Day Treatment" for a full explanation of the criteria for eligibility.

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18. AODA Currently: Does the recipient currently exhibit dependence on or abuse of alcohol or other drugs? Check the appropriate answer.

19. MR Primary Diagnosis: Does the recipient have a primary diagnosis of mental retardation? Mental retardation is defined as anyone with a diagnosis of 317, 318, or 319, according to the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9).

20. ICD-9 Primary/Secondary Diagnosis: List the primary and secondary diagnoses according to the ICD-9. Do not use any other coding structure.

21. Total Score LOF: Indicate the three scores from the functional assessment scales in the following order: 1) Task Orientation Scale, 2) Social Functioning Scale, and 3) Emotional Functioning Scale. Then add the scores for the total level of functioning (LOF) score. The score for each scale is the number of the set of statements which best describes the recipient's level of functioning.

22. Likelihood of Benefit: Indicate the answer from page 5, question 5, of the functional assessment scales.

23. Course of Functioning Score: Indicate the answer from page 5, question 6, of the functional assessment scales. The course of functioning score is the sum of the scores for Parts A-E.

24. Risk of Hospitalization: Indicate the answer from page 5, question 7, of the functional assessment scales. This item does not need to be completed unless the answer to item 23 of this form was between 13 and 25.

25. Current Services Being Received: Indicate any services the recipient is receiving in addition to day treatment. For example, is the recipient receiving psychotherapy or occupational therapy in addition to day treatment from your facility? Does the recipient attend a sheltered workshop? Does the recipient receive social work services from the county? Does the recipient have a guardian or advocate? These are the types of services (both medical and nonmedical) that should be indicated. If this information is not known, check with the referral source, the county social service office, or the recipient's place of residence.

26. Name of Day Treatment Program/Signatures: Print the name of the day treatment program. The person performing the functional assessment (e.g., case manager or primary staff person) must sign and indicate his or her discipline. The day treatment program director must also sign after reviewing the assessment form.

27. Authorization: (not required)

28. Approval Given For: (not required)

29. Referral Source Code: These are the descriptions of the codes used in item 8 of this form.